MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-2)

CERTIFICATE OF DEATH

T 05217

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince Geo
City or town: No Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 Yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Geo.
City or town: Brentwood Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Sallie A. Adams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Wm Adams
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 18 1869

8. AGE: Years: 76 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Buck Taylor
13. Birthplace: Va
MOTHER 14. Maiden name: Jane Branham
15. Birthplace: Va
16. Informant: Mrs Daisy A. Newton
Address: 4535 - 41st Ave Brentwood Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5. 4. 45 (month) (day) (year)
Cemetery or crematory: Lincoln Memorial Cemetery
Location: Suitland Md
18. Funeral director: Robert E. Lee Funeral
Address: 1810 - 9th St. NW Wash DC
19. 5/1 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1945, at 3:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1945, to May 1 1945
and that I last saw h[illegible] alive on May 1 1945

Immediate cause of death	DURATION
Carcinoma uteri	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. L. Gudson M. D. or other
Address: Laurel, Md Date signed: May 1, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

T 05218

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred: 4408 - 41st Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4408 - 41st Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Catherine Anne Allison

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William Terry Allison
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 9, 1864

8. AGE: Years	Months	Days	If less than one day
80	9	15	..... hrs. ..... min.

9. Birthplace Canada (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name William Mears
13. Birthplace Canada

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Agatha Willett
Address 4408 - 41st Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Maryland road
16. Funeral director F. Gasaliss Sons
Address Hyattsville road

19. May 25 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 45 at 12 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Deputy Medical Examiner James D. Bowie M. D. or other
Address Forestville md Date signed 5-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

0524

Reg. Dint. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 years

Hospital, institution, or street address where death occurred:

3411 Tilden Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infnnts give residence of mother)

State Maryland County Prince Georges

City or town Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3411 Tilden Street

(If rural, give LOCATION)

2.(a) If veteran, name war 578-18-9882 A

3.(a) FULL NAME Isaac David Arnold

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Abbie Dishmann Arnold

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) October 29, 1859

8. AGE: Years 85 | Months 7 | Days | If less than one day ... hrs. ... min.

9. Birthplace Stafford County, Virginia (Town, county, and state)

10. Usual occupation

11. Industry or business Shoe business

FATHER 12. Name John Arnold

13. Birthplace Willow Hill, King George Co., Va.

MOTHER 14. Maiden name Mary Jane Holmes

15. Birthplace King George County, Va.

16. Informant Abbie Dishmann Arnold

Address 3411 Tilden Street, Brentwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1945 (month) (day) (year)

Cemetery or crematory Pohick Church Yard

Location Pohick, Fairfax County, Virginia

18. Funeral director E. Gaeta Stone

Address Hyattsville Md

19. June 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1943, to May 29 1945 and that I last saw him alive on 5/29 1945

Immediate cause of death	DURATION
Myocardial failure	2 wks
Due to Cardio-renal-vascular disease	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. W. Conklin MD M. D. or other

Address 3100-20-NE Date signed 5/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Lanham Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
Street No.: none
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lottie L. Bentley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

8.(b) Name of husband or wife: —
8.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 14 1865

8. AGE: Years	Months	Days	If less than one day
80	3	21	____ hrs. ____ min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Gov Clerk
11. Industry or business
12. FATHER — Name: Charles W Bentley
13. FATHER — Birthplace: Conn.
14. MOTHER — Maiden name: Ann Laty
15. MOTHER — Birthplace: Md.
16. Informant: Lillie C Corridon
Address: Lanham md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8-45 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore md
18. Funeral director: J Gaspchs Sons
Address: Hyattsville md
19. May 7 1845 (Date rec'd by registrar) Mrs Jack Bennette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1945 at 4 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1945 to May 5 1945
and that I last saw h.. alive on May 4 1945

Immediate cause of death	DURATION
Myocarditis	?
Due to	
Due to	
Other conditions: Chr. Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op.: ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ____ Injured at work?

23. SIGNATURE: John J. Malonum M.D. M. D. or other
Address: Cheverly md Date signed: 5-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth is shown on FILM No G 94 MAY 17 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

B 752217

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Bro Geo Co. City or town Sacret Heart Home Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore Md.
City or town 34 E. Austead st Baltimore Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war V

3. (a) FULL NAME John Bornschlegl

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife Emma Koll Bornschlegl
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22. 1858 1857

8. AGE: Years	Months	Days	If less than one day
87			hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

MOTHER FATHER
12. Name George Bornschlegl
13. Birthplace Germany
14. Maiden name Catherine Kreamer
15. Birthplace Germany

16. Informant Sacrit Heart Home
Address Hyattsville. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1945 (month) (day) (year)
Cemetery or crematory Holy Cross
Location Anne Arundel Co Md

18. Funeral director Bernard C. Harle
Address Baltimore Md

19. May 12, 1945 James Devey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12. 1945 at 6.30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 19 45 to May 12 19 45 and that I last saw h alive on May 11 19 45

Immediate cause of death	DURATION
1 Arterio clerotic heart disease	1 year
2 Congestive Failure	1 week
Due to Fracture right hip	3 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Acc. Date of 3 or 4 days before death
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Sacred Heart Home
Means of injury Fell when getting out of bed. Injured at work?

Thomas F. Collins
23. SIGNATURE Thomas F Collins M.D. M. D. or other
Address 5224 H St. N.E. Date signed 5-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

approved by Lt James L Boyd
medical Examiner
Pro Geo Co. Md.

Evidence for change of year of birth of deceased is shown on FILM No. G 95 MAY 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15a)

CERTIFICATE OF DEATH

Reg. Dist. No. 05222 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 49 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Riggs Rd. (Mothers Jones Rest Home)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Julia Prettyman Botts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
female	white	widowed

6.(b) Name of husband or wife: John A Botts
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 1, 1849

8. AGE: Years	Months	Days	If less than one day
96	3	10	..... hrs. ..... min.

9. Birthplace: Washington DC (Town, county, and state)
10. Usual occupation: none
11. Industry or business:
12. FATHER — Name: Unknown
13. FATHER — Birthplace:
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace:
16. Informant: Stella Folsom
Address: 216-13th St NE. Wash, DC.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 14 1945 (month) (day) (year)
Cemetery or crematory: Arlington Annex
Location:
18. Funeral director: J W M Lee Sons
Address: 300-4th St NE
19. May 10 1945 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945, at 6 00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions: Fracture Femur right hip	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 3-23-45
Where did injury occur? Hyattsville P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Fell getting out bed Injured at work? no
Reported medical Examiner
23. SIGNATURE: James D. Ford M. D. or other
Address: Forestville Md Date signed: 5-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

T 5223

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days.
Hospital, Institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George.
City or town Mt. Ranier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4908 Ranier Ave. Mt. Ranier
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Brown.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1881

8. AGE: Years	Months	Days	If less than one day
63	7	10	..... hrs. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

FATHER
12. Name Winfield Brown.
13. Birthplace Va.

MOTHER
14. Maiden name Sara Rhodes
15. Birthplace Va.

16. Informant Mrs. Margaret Ranier
Address 4114 - 38nd St. Mt. Ranier, Md.

17. (Burial, cremation, or removal. Which?) Date thereof May 14, 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Bladensburg Rd. & D.C. Line

18. Funeral director Wm. J. Malley
Address 3200 - R.I. Ave, Mt. Ranier, Md.

19. 5/13/45 (Date rec'd by registrar) Amanda L. Downes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945, at 11:55 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 19 43, to May 10, 1945.
and that I last saw him alive on May 10, 1945.

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	2 yrs.
Due to	
Due to	
Other conditions Chronic Congestive Heart Failure - Ascites - Left Hemothoray	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, ~~in industry~~, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE ..... M. D. or ~~other~~
Address Mt. Ranier Md. Date signed 5/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's County
City or town: Rural - Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 816- L. St., S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: OLIVER BROWN

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Elizabeth Brown
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): October 7, 1882

8. AGE: Years	Months	Days	If less than one day
62	6	27	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Porter in grocery store
11. Industry or business: -

FATHER
12. Name: John Henry Brown
13. Birthplace: St. Mary's Co., Md.

MOTHER
14. Maiden name: Rebecca Palmer
15. Birthplace: St. Mary's Co., Md.

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5 - 4 - 45 (month) (day) (year)
Cemetery or crematory: to Wash., D C
Location

18. Funeral director: Barnes Mattews
Address: 614 4th st SW

19. May 3 1945 Rowland & Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3, 1945, at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 21, 1945, to May 3, 1945
and that I last saw him alive on May 3, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glen Dale, Md. Date signed: 5/3/45

705225

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (457)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George Co.
City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred: Prince Georges Gen Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Prince George
City or town Hyattsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 4004 Gallatin (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Eliza Burleigh

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug 12 1885

8. AGE:

Years	Months	Days	If less than one day
59	8		... hrs. ... min.

9. Birthplace Scotland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Mr William Lawrence
13. Birthplace Scotland
MOTHER 14. Maiden name Anne Gordon
15. Birthplace Scotland
16. Informant foster daughter Marjorie Christie
Address 4004 Gallatin St. Hyattsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-24-45 (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery
Location Wash. D.C.
18. Funeral director W W Chambers Co
Address Riverdale Md
19. 5/23 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-7 1945, to 5-22 1945
and that I last saw her alive on 5-21 1945

Immediate cause of death	DURATION
Carcinoma of Pharynx with complete Closure of Esophagus	? 1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE W B Moyers M.D. M. D. or other
Address 3303 Penn St. Mt. Rainier Md Date signed 5-22-45

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

05231

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland, County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 101 Elm Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Virginia Beauregard Camp

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fe	White	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 20, 1863

8. AGE:

Years	Months	Days	If less than one day
82		20	____ hrs. ____ min.

9. Birthplace: Norfolk, Virginia (Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER
12. Name: Thomas B Camp
13. Birthplace: Norfolk, Va

MOTHER
14. Maiden name: Nancy Jane Clarke
15. Birthplace: Norfolk Va

16. Informant: Hospital Records + Mrs Hammer
Address: 101 Elm Ave, Kensington Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 8 1945 (month) (day) (year)
Cemetery or crematory: Washington, D.C.
Location:

18. Funeral director: L P Hines Co
Address: 2901 - 14th St NW

19. 5/5/45 19____ (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1945, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 16 1945, to May 5 1945 and that I last saw h[er] alive on May 5 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 hrs.
Due to: General arteriosclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: L C Nealon MD (M. D. or other)
Address: Riverdale, Md Date signed: 5-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

05232

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince Georges
City or town: Melwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: Marlboro Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Melwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Marlboro Pike
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Walter Robert Cook

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 6, 1858

8. AGE: Years: 87 | Months: 11 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: Md

16. Informant: Charles F. Sweeney
Address: Melwood, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-12-45 (month) (day) (year)
Cemetery or crematory: St. Barnabas
Location: Leland, Md.

18. Funeral director: Ritchie Brothers
Address: Upper Marlboro, Md.

19. May 11, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1945, at 4:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James F. Boyd M. D. or other
Address: Forestville, Md. Date signed: 5-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05233

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9½ hrs

Hospital, Institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 9½ hr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Greenbelt

(If outside city or town limits, write RURAL and give nearest town)

Street No. 30-4 Ridge Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Carol Jean Cooley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fe	W	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8, 1942

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
3	2			

9. Birthplace: Washington, D C (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Mitchel Washington Cooley

13. Birthplace: Clarksburg, Md.

MOTHER — 14. Maiden name: Ella Mae Mawburn

15. Birthplace: Baltimore, Md.

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/10/45 (month) (day) (year)

Cemetery or crematory: Monocacy

Location: Braddock, Md

18. Funeral director: Wm B. Hilton

Address: Barnesville, Md.

19. (Date rec'd by registrar) May 9 1945 James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1945, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to May 8 1945 and that I last saw her alive on May 8 1945

Immediate cause of death	DURATION
Ether anesthesia and anoxemia	6 hrs
Due to: Tonsilectomy	
Due to: Chronic tonsulitis	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: hypertrophied tonsils

Date of op. 5-8-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Hans Wodak M.D. (M. D. or other)

Address: 30-D Ridge Rd Greenbelt Date signed: 5-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

T 05226

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mos., 15 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 10 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 919 G. St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frank Costales

3.(b) Social Security Number: 578-01-5311

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Filipino	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 4, 1901

8. AGE: Years	Months	Days	If less than one day
43	7	1	hrs. min.

9. Birthplace: Naguilian, Phillipine Islands
(Town, county, and state)

10. Usual occupation: Restuarant Worker

11. Industry or business:

FATHER
12. Name: Liberto Costales
13. Birthplace: Phillipine Islands

MOTHER
14. Maiden name: Milchara Mayo
15. Birthplace: Phillipine Islands

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5/5/45 (month) (day) (year)

Cemetery or crematory: Washington D. C.

Location:

18. Funeral director: J. William Leis Sons Co

Address: 300 - 4 St NE Washington D.C.

19. May 5, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 19 45, at 1:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 19 44, to May 5, 19 45 and that I last saw h. alive on May 5 19 45

Immediate cause of death	DURATION
Cardiorespiratory tuberculosis	11 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Dineare M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 5/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-2)

CERTIFICATE OF DEATH

#5234

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred: Bowie Laurel Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Prince Georges
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bowie Laurel Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George Daniels

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years: 70 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Thomas A. Hall
Address: Bowie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17-45 (month) (day) (year)
Cemetery or crematory: Laytham
Location: Laytham

18. Funeral director: W. Gladys Sons
Address: Bowie Md

19. May 17 1945 (Date rec'd by registrar) Mrs. J. W. Yingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945, at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James E. Bowie M.D., or other
Address: Forestville, Md. Date signed: 5-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05235 230
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Town of Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two weeks
Hospital, Institution, or street address where death occurred:
Greenbelt Road, Bowie, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
Albert Sidney Davis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widower

6.(b) Name of husband or wife: ? Shipley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1862

8. AGE: Years	Months	Days	If less than one day
83		11	hrs. min.

9. Birthplace: Montgomery County
(Town, county, and state)
10. Usual occupation: Monumental works
11. Industry or business: Gravestones
FATHER 12. Name: Hans Davis
13. Birthplace: Montgomery, Counties
MOTHER 14. Maiden name: ? Shipley
15. Birthplace: Montgomery, County
16. Informant: Elsie Davis, daughter
Address: Washington, D. C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7, 1945 (month) (day) (year)
Cemetery or crematory: Ivy Hill Cemetary
Location: Laurel, Maryland
18. Funeral director: J. A. Frank Jay
Address: Washington, D. C.
19. May 8th 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 19 45, at 7 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 19 45, to May 4 19 45
and that I last saw him alive on May 2 19 45

Immediate cause of death	DURATION
Cerebral Thrombosis	1 week
Due to: General Arteriosclerosis	20 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. W. Malin MD
M. D. or other
Address: Riverdale, Md. Date signed: 5-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

(5227) Reg. Dist. No. 232

1. PLACE OF DEATH:
County Prince Georges
City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life's
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frances Ella Harris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1945

8. AGE: Years | Months: 3 | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name LeRoy Harris
13. Birthplace Maryland

MOTHER
14. Maiden name Lonie Washington
15. Birthplace Maryland

16. Informant Mrs. Lonie Harris
Address Cheltenham, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1945 (month) (day) (year)
Cemetery or crematory Holy Rosary
Location Rosaryville, Md.
18. Funeral director LeRoy Davis
Address Cheltenham Md.

19. May 19 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 45, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to Overlying by mother	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5-19-45
Where did injury occur? Cheltenham (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Mother lay on baby Injured at work?

Deputy Medical Examiner
23. SIGNATURE ..... M. D. or other
Address Forestville Md. Date signed 5-19-45

VS A15 (T)

(1)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05228

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 9 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1010 - 11th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: DEREMER, GEORGIA M

3.(b) Social Security Number: 182-10-3286

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married (separated)

6.(b) Name of husband or wife: Russell Deremer
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 14, 1919

8. AGE:

Years	Months	Days	If less than one day
26	-	17	...hrs. ...min.

9. Birthplace: Savage, Maryland (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business: -

FATHER
12. Name: Richard H. Ford
13. Birthplace: Culpepper, Virginia

MOTHER
14. Maiden name: Addie Shipe
15. Birthplace: Detrick, Virginia

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 1, 1945 (month) (day) (year)
Cemetery or crematory
Location: Laurel, Md.
18. Funeral director: W. B. Selby
Address: Laurel Md

19. May 1, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1945 at 2 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1945 to May 1 1945 and that I last saw h. alive on May 1, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	1 mo 10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 5-1-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F-75236

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prg Geo Co
City or town: Edmonston Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prg Geo Co
City or town: Edmonston Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5214 Decatur st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Virginia Sturall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: July 22, 1863

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE:

Years	Months	Days	If less than one day
82	—	—	..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: At home
11. Industry or business

FATHER
12. Name: Edward B. Sturall
13. Birthplace: Ohio

MOTHER
14. Maiden name: Sarah A Robinson
15. Birthplace: Ohio

16. Informant: Edward Sturall
Address: Edmonston Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16. 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Washington D.C.

18. Funeral director: J Blascic sons
Address: Hyattsville Md.

19. May 14 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1945, at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 45 to 5-14 19 45
and that I last saw h w alive on May 2 19 45

Immediate cause of death: myocarditis — DURATION: 10 hr

Due to: — DURATION:

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lemuel Hays M. D. or other
Address: Hyatts, Md Date signed: 5-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


MAY 16 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05230

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 6 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 446 N. Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: CHARLES ELLIS

3.(b) Social Security Number: 578-05-5264

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Libby Ellis

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 4, 1894

8. AGE: Years	Months	Days	If less than one day
50	10	22	...hrs. ...min.

9. Birthplace: Orange, Virginia
(Town, county, and state)

10. Usual occupation: Cement Worker

11. Industry or business:

FATHER — 12. Name: Horace Ellis

13. Birthplace: Orange, Virginia

MOTHER — 14. Maiden name: Mary Walker

15. Birthplace: Orange, Virginia

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 27, 1945 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: W Ernest Jarvis Co

Address: 1432 You St NW

19. May 26 1945 (Date rec'd by registrar) Rowland S. Phillips Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26, 1945, at 3.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 20, 1945, to May 26, 1945 and that I last saw h... alive on May 26, 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mo
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Tuberculosis of entire left lung with multiple cavities, hemorrhage from one, and spread with several area of bronchopneumonia tuberculous in right lung.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 5/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 05229

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5219 Georgia Avenue N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EVERETT EARL

3.(b) Social Security Number: 217-05-2929

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth Everett Earl
6.(c) If alive, give age: 25 years
7. Birth date of deceased (mo., day, yr.): July 6, 1902

8. AGE: Years	Months	Days	If less than one day
42	10	13	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:

FATHER
12. Name: Edward Earl
13. Birthplace: New Jersey

MOTHER
14. Maiden name: Margaret Young
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5-19-45 (month) (day) (year)
Cemetery or crematory: to Wash. DC
Location:

18. Funeral director: The Huntemann Funeral Home
Address: 5732 Georgia Ave N.W.

19. May 19 1945 (Date rec'd by registrar) Rowland S. Phibbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 19 1945 at 1:10 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from MAY 16 1945, to MAY 19 1945
and that I last saw h.. alive on MAY 19 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	1 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Kind of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md Date signed: 5/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

T 05237

CERTIFICATE OF DEATH

Reg. Diat. No. 234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pr. Geo's Co.
City or town: Silver Hill Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo's Co.
City or town: Silver Hill Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5371 - Auth Road S. E. Wash. 20, D. C.
5371 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Morgan Everett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice S. Everett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 30th. 1888

8. AGE:	Years	Months	Days	If less than one day
	56			hrs. min.

9. Birthplace: Pr. Geo's Co., Maryland.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: William B. Everett
13. Birthplace: Va.

MOTHER
14. Maiden name: Addie Carr
15. Birthplace: Washington, D. C.

16. Informant: Mrs. Alice S. Everett
Address: 5371- Auth Road S. E. Wash., 20, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28-1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Maryland
18. Funeral director: Thomas F. Murray
Address: 2007- Nichols Ave. S. E. Washington, D. C.

19. May 25 1945 (Date rec'd by registrar) Howard J. Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945, at 5-45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to May 25 1945 and that I last saw him alive on May 23 1945

	DURATION
Immediate cause of death: Acute myocardial failure	2 hrs
Due to: Chronic myocarditis	2 years
Due to: General arteriosclerosis	many
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D., or other
Address: Washington 19DC Date signed: May 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

05238

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: PRINCE GEORGES
City or town: HYATTSVILLE (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 YEAR 2 MO.
Hospital, Institution, or street address where death occurred:
SACRED HEART HOME
How long in hospital or institution? 1 YR. 2 MO.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: WASHINGTON (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1408 WEBSTER ST. N.W (If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: HANNAH FITZGERALD

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: THOMAS B.
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 2/6/64

8. AGE: Years	Months	Days	If less than one day
81			hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Patrick Murphy
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Garrity
15. Birthplace: Ireland

16. Informant: Sacred Heart Home Records
Address: Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-11-45 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cemetery
Location: Washington D.C.

18. Funeral director: Francis J Collins
Address: 3821-14th St. NW.

19. May 10 1945 (Date rec'd by registrar) James Berry (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1945, at 8 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1945 to May 9 1945 and that I last saw h... alive on May 8 1945

Immediate cause of death	DURATION
Congestive Heart Failure	2 weeks
Arteriosclerotic Heart Dis...	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thomas F Collins M.D. (M. D. or other)
Address: 322 H St NE Date signed: May 9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-9)

05239

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH:
County: Prince Georges
City or town: RURAL- Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: #4 Bellevue Court, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: JAMES FOREST

3.(b) Social Security Number: - (lost)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 2, 1894

8. AGE: Years	Months	Days	If less than one day
50	8	17	hrs. min.

9. Birthplace: ? - Maryland (Town, county, and state)
10. Usual occupation: General work around grocery store
11. Industry or business

FATHER
12. Name: George Forest
13. Birthplace: ?, Maryland

MOTHER
14. Maiden name: Emma Johnson
15. Birthplace: ? , Maryland

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-19-45 (month) (day) (year)
Cemetery or crematory: To Wash. D.C.
Location

18. Funeral director: Henry S. Washington & Son
Address: 467 - N St. N.W.

19. May 18, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1945, at 2.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 26, 1945, to May 18, 1945, and that I last saw him alive on May 18, 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	16 mo
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 5/18/45

Evidence for change of birth date of deceased is shown on FILM No. G95 MAY 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

05240 T

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George Co.
City or town: Chevelly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Prince George Hosp
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Prince Geo Co
City or town: College Park Md (If outside city or town limits, write RURAL and give nearest town)
Street No. 4600 Hartwick Rd. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Geo Myrtle Green.

3.(b) Social Security Number:

4. Sex: Female | 5. Color or race: W. | 6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13 1873 ~~1875~~

8. AGE: Years: 69 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Arkansas (Town, county, and state)

10. Usual occupation: H. W.

11. Industry or business:

FATHER — 12. Name: Walter Jobbin
13. Birthplace: Isle of White. England

MOTHER — 14. Maiden name: Margret Cave
15. Birthplace: Arkansas

16. Informant: Son Walter Green
Address: 7002. Wake Forest Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12, 1945 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: Colmar Manor Md

18. Funeral director: F Gracie Sons
Address: Hyatteville Md

19. 5/12 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1945, at 1.145 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1943, to May 10 1945
and that I last saw h.. alive on May 10 1945

	DURATION
Immediate cause of death: Cause Coronary Thrombosis	2 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Collect 4 Md. M. D. or other
Address: Hyattsville Md Date signed: 5-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

T 05241

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos., 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 904 - 1st Street S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: FREDRIC D. HALL

3.(b) Social Security Number: 579-20-9927

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): May 26, 1926

8. AGE: Years	Months	Days	If less than one day
18	11	9	....hrs. ....min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Messenger (Gov't.)
11. Industry or business: –

FATHER
12. Name: Kirby L. Hall
13. Birthplace: Mississippi

MOTHER
14. Maiden name: Virginia Bennett
15. Birthplace: Mississippi

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/6/45 (month) (day) (year)
Cemetery or crematory
Location: To Washington, D.C.
18. Funeral director: John T. Rhines & Co.
Address: 901 - 3rd St. S.W.

19. May 5 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5, 1945 at 5.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17, 1945 to May 5 1945
and that I last saw h... alive on May 5 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 5/5/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

05242

(134-a)

1. PLACE OF DEATH

County Prince George — Registration Dist. No. 245

Village or City Hyattsville — No. 2204 Gunn Chapel Rd St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME William Leonard Halford

(a) Residence: No. 2204 Gunn Chapel Rd St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of Lillian Kline

6. DATE OF BIRTH (month, day, and year) ? 1909

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
36			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Motor Car Oper

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Capital Transit Co

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) South Carolina (State or country)

FATHER

13. NAME James Halford

14. BIRTHPLACE (city or town) D.C. (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) ... (State or country)

17. INFORMANT Lillian K. Halford (Address) 2204 Gunn Chapel Rd

18. BURIAL, CREMATION, OR REMOVAL Place Strasburg Va Date 5/5, 1945

19. UNDERTAKER J. S. Evelyn (Address) Alexandria Va

20. FILED May 3, 1945 James Lacey Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 3 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 20, 1942 to May 3, 1945

I last saw h. liv. alive on April 20, 1945; death is said to have occurred on the date stated above, at 7:55 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Azotemia	
Toxemia	

Other Contributory Causes of importance:

1. Bilateral Staghorn Calculi kidneys
2. Bilateral Pyelonephrosis

Name of operation ... Date of ...

What test confirmed diagnosis? X-ray & lab. Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicida, or homicida? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Clifford E. Bagley M. D.

(Address) 1801 Eye St N.W. Washington, D.C.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home.** For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

45245
05243

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 11 mo
Hospital, institution, or street address where death occurred:
Sacred Heart Home
How long in hospital or institution? 1 yr 11 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D C County:
City or town: WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1225 Monroe St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: MARY L. HORNIG

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

B.(b) Name of husband or wife: John Gustav Horning
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 11, 1859

8. AGE: Years 85 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Charles Hartel
13. Birthplace: Germany

MOTHER
14. Maiden name: Amelia Reese
15. Birthplace: Germany

16. Informant: Sacred Heart Home Records
Address: Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-4-45 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cemetery
Location: Washington, D.C.

18. Funeral director: Francis Collins
Address: 3821-14th St. NW Wash, D.C.

19. May 31 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1945 at 1p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 15 1936 to May 31 1945
and that I last saw h[illegible] alive on May 31 1945

Immediate cause of death	DURATION
Acute Congestive Cardiac Failure	
Hypostatic Pneumonia	
Due to: Myocarditis	
Due to:	
Other conditions: Arteriosclerosis	
Generalized atypical arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury Injured at work?

23. SIGNATURE: H Courtney MD M. D. or other
Address: 5601- 4th St NW Date signed: May 31 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

05244

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George Co.
City or town Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 Minutes
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 20 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George Co.
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Queens Chapel Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Susie V. Dager

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife William A. Dager
6.(c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) Aug 11, 1883

8. AGE: Years	Months	Days	If less than one day
59			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Ellsworth Mc Cheney
13. Birthplace Maryland

MOTHER
14. Maiden name Loretta Teasdale
15. Birthplace Va

16. Informant son, Clyde Dager
Address 7303 Glenside Drive. Takoma Park
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21. 1945 (month) (day) (year)
Cemetery or crematory Geo Washington
Location Berwyn Md.
18. Funeral director F. Coale Sons
Address Hyattsville Md.
19. 5/21 1945 Amanda Dauney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Saturday May 19 1945 at 12 45 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardio Vascular Renal disease	
Due to	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Deputy medical Examiner

23. SIGNATURE ..... M. D. or other
Address Forestville Md Date signed 5-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on

FILM No. G 95 JUN 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1395)

CERTIFICATE OF DEATH

#5245

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 day
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 33 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6341/2 - 14th St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jones, Mrs. Eleanor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married.

6.(b) Name of husband or wife Jones, Mr.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1908

8. AGE: Years	Months	Days	If less than one day
37 ~~36~~	4	9	..... hrs. ..... min.

9. Birthplace District of Columbia (Town, county, and state)
10. Usual occupation H. W.
11. Industry or business

FATHER
12. Name Jones, Mr. Wm.
13. Birthplace Va.

MOTHER
14. Maiden name Anderson,
15. Birthplace Md.

16. Informant Jones, Mr. Kenneth
Address 6347 - 14th St. Washington, D.C.
17. Removal to Wash. D.C. (Burial, cremation, or removal. Which?) Date thereof May 27 45 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Md.
18. Funeral director Albert Funke
Address 641 - H St. N.E. Wash. D.C.
19. 5/27 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1945 at 12 1/2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~May~~ April 25 1945 to May 27 1945 and that I last saw her alive on May 27 1945

Immediate cause of death	DURATION
general peritonitis (postoperative)	1 mo - 2 days.
Due to Ruptured tubal abscess	
Due to	
Other conditions Septicemia	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Same.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address H St. N.E. Washington D.C. Date signed 5-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age & birth date of deceased is shown on FILM No. G 95 MAY 22 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05246

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12
Hospital, institution, or street address where death occurred: Prince George General Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harold King

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Rose King
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 24 -77- 1878

8. AGE: Years	Months	Days	If less than one day
67 6/-	2	17	..... hrs. ..... min.

9. Birthplace: Coolville, Ohio (Town, county, and state)
10. Usual occupation: car inspector.
11. Industry or business

FATHER
12. Name: George W. King
13. Birthplace: Shellacarty, Ohio.

MOTHER
14. Maiden name: Susannah MacKeroy
15. Birthplace: Wheeling, W. Va.

16. Informant: Mrs. Rose King.
Address: Seat Pleasant, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location

18. Funeral director: Deal Funeral Home
Address: 4812 Ga. Ave. N.W., Wash., D.C.

19. May 10 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1945, at 9 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1945, to May 9 1945 and that I last saw h.. alive on May 9 1945

Immediate cause of death: Carcinoma of liver — DURATION
Arteriosclerosis
Secondary anemia
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James E. Sasscer M.D. or other
Address: Upper Marlboro, Md. Date signed: 5-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05247 Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Prince George's Gen. Hospt.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317 - 17th St., N.E. Washington D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Kress, Mr. Frank

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	W.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1864

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
80 yrs.				

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Kress, Frederick
13. Birthplace: Germany

MOTHER
14. Maiden name: Kusek, Katherine
15. Birthplace: Ireland

16. Informant: Stevenson, Mr. S. W.
Address: 52 Hamilton St., N.W. Washington D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 8 1945 (month) (day) (year)
Cemetery or crematory: Washington, D.C.
Location:
18. Funeral director: William Lee's Sons
Address: 360 - 4th St. N.E.
19. 5/8 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1945, at 6:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-1 1945, to 5-8 1945
and that I last saw him alive on 5-7 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	?
Tuberculosis Pneumonia	8 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. B. Moyer M.D.
M. D. or other
3303 Bunker Hill Rd. Mt. Rainier Md.
Address: Date signed: 5-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

05248

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: ~~Pro~~ Geo co:

City or town: Landover Hills Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pro Geo co

City or town: Landover Hills Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4202 - 70 th st

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Blanche Martin Langmead

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Harry Langmead

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb 15, 1870

8. AGE:

Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: Peter Martin

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Margaret Henstall

15. Birthplace: Md

16. Informant: Jeanne B. Kleine

Address: Landover Hills Md

17. (Burial, cremation, or removal. Which?) transportation Date thereof: May 21, 1945 (month) (day) (year)

Cemetery or crematory: Cincinatti Ohio

Location: Cincinatti Ohio

18. Funeral director: I Gaschi sons

Address: Hyattsville Md

19. 5/21 19 45 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1945, at 6:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1945, to May 20, 1945, and that I last saw her alive on May 13, 1945.

Immediate cause of death	DURATION
Angina Pectoris	
Due to: Myocardial Insufficiency	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A Clerit M.D. M. D. or other

Address: Hyattsville Md Date signed: 5-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

05249

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, Institution, or street address where death occurred:
3721-35th Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3721-35th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Fred Charles Lewis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Rachel C Lewis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 15, 1897

8. AGE:

Years	Months	Days	If less than one day
48	2	5	..... hrs. ..... min.

9. Birthplace Ohio (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Rachel C Lewis
Address 3721-35th, Mt Rainier Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Wash.-Balto. Blvd. + D.C. Line Md.
18. Funeral director Wm. J. Malloy
Address 3200-R.I. Ave. Mt Rainier Md.
19. May 22, 1945 (Date rec'd by registrar) James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 45, at 3 15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary thrombosis	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James L. Long M.D. or other
Address Forestville Md Date signed 5-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G95 JUN 5 1945.

(15251)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (a)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cottage City md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Pr. George
City or town Cottage City md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4015 Bunker Hill Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary F. Martin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Lester Martin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2 - 1876

8. AGE: Years	Months	Days	If less than one day
69	0	18	hrs. min.

9. Birthplace: Brooklyn, New York (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER	12. Name: Thomas Fox
	13. Birthplace: Ny
MOTHER	14. Maiden name: Mary Parker
	15. Birthplace: Ny

16. Informant: Grace Hollack [redacted]
Address: 4015 Bunker Hill Rd Cottage City md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-24-45 (month) (day) (year)
Cemetery or crematory: Hollis cemetery
Location: Hollis Long Island New York
18. Funeral director: W W Chambers Co
Address: Riverdale, md
19. 5/21 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1945, at 5:30 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cancer of ovary and pelvic disease	
Due to	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy medical examiner
23. SIGNATURE: James T. Boyd M. D. or other
Address: Forestville md Date signed 5-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

05251

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County Prince Georges
City or town Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred: 11th Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland, County Prince George
City or town Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Mason

3.(b) Social Security Number

4. Sex Male
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 Months Days If less than one day ... hrs. ... min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Lloyd Baker
Address Bowie Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12-45 (month) (day) (year)
Cemetery or crematory Fladungs
Location Pr Geo Co
18. Funeral director Martin Fladung Sons
Address Bowie Md

19. May 10 1945 Mrs. J. W. Yingling
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945 at 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE [illegible] M.D. or other
Address Forestville Md Date signed 5-9-45

(I)

(T)


RECEIVED
MAY 12 1945

05252

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George 's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos., 24 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 6 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1826 M. Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: EDWARD J. MASTERSON

3.(b) Social Security Number: 578-18-0145

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 20, 1920

8. AGE: Years	Months	Days	If less than one day
25	3	7	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Julius Masterson
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Rose Davis
15. Birthplace: Washington, D. C.

18. Informant: Decedent.
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 27, 1945 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D. C

19. Funeral director: Thomas Frazier Co
Address: 389 R. I. Ave N. W.

18. May 27, 1945 Rowland S. Philips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1945 at 1245 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 3, 1944, to May 27, 1945 and that I last saw h. alive on May 26, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 5/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

05253

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred:
Eugene Leland Memorial Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: University Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4304 Van Buren St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Merriam, Mrs Josephine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thaddeus Young Merriam
Deceased
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 17 1859

8. AGE: Years: 85 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Iowa (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER
12. Name: John Tilden Howard
13. Birthplace: Mass

MOTHER
14. Maiden name: Kate Lucinda Stebbins
15. Birthplace: New York

16. Informant: Hospital Records as given by daughter on admission
Address:

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: May 30, 1945 (month) (day) (year)
Cemetery or crematory: La Grange, Illinois
Location:

18. Funeral director: F. Gerachi Sons
Address: Hyattsville, Md.

19. May 30 1945 (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1945, at 5-25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1945, to May 29 1945
and that I last saw h[illegible] alive on May 28 1945

Immediate cause of death	DURATION
Senility	6 Mo
Due to: General arteriosclerosis	10 Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L W. Malin M.D.
M. D. or other
Address: Riverdale Md. Date signed: 5-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47cd)

05254

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6318 Powhatan St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Moran, Mr. Leo

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Elizabeth R. Moran
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb-9-1888

8. AGE: Years	Months	Days	If less than one day
57	3	13	..... hrs. ..... min.

9. Birthplace: Wisconsin
(Town, county, and state)
10. Usual occupation: retired
11. Industry or business

FATHER
12. Name: James Moran
13. Birthplace: Wisconsin

MOTHER
14. Maiden name: Johanna Lacey
15. Birthplace: Wisconsin

16. Informant: Mrs. Elizabeth Moran
Address: 6318 Powhatan St, Riverdale, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 23, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: W W Chambers Co.
Address: Riverdale, Md.
19. 5/23 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945 at 7:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1945, to May 22 1945 and that I last saw him alive on May 22 1945
Immediate cause of death: Cancer Duo Malnutrition — DURATION
Due to: Emphysema with Cirrhosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo. H. Hague M. D. or other
Address: 3717-3rd St. N.E. Date signed: 5-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 2552 — 05255

1. PLACE OF DEATH:
County Prince George
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gertrude Veronica Mudd

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Edward J. Mudd
6.(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) January 7 - 1876

8. AGE:

Years	Months	Days	If less than one day
69	4	8	hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation At home
11. Industry or business
FATHER 12. Name James Casey
13. Birthplace Ireland
MOTHER 14. Maiden name Unknown
15. Birthplace Ireland
16. Informant Edward J. Mudd
Address Upper Marlboro, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-17-45 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Washington, D. C.
18. Funeral director Tibbie Brothers
Address Upper Marlboro Md.
19. May 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1945 to May 15 1945
and that I last saw h.er alive on May 14 1945

	DURATION
Immediate cause of death Coronary Thrombosis	20 hrs.
Due to Hypertension with Cardio-Vascular Renal Disease	10 yrs
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James E. Janseer M. D. or other
Address Upper Marlboro Md. Date signed 5-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

05256

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince Georges

City or town Beltsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Innocent

Hospital, institution, or street address where death occurred:

In a field

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. U. S. Naval Air Station

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Oscar Needham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife Theresa Needham

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 20, 1911

8. AGE:	Years	Months	Days	If less than one day
	33	9	27	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Officer

11. Industry or business U. S. Navy

FATHER 12. Name

13. Birthplace Unknown

MOTHER 14. Maiden name

15. Birthplace Unknown

16. Informant U. S. Navy Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-45 (month) (day) (year)

Cemetery or crematory Arlington Nat.

Location Washington D.C.

18. Funeral director H. W. Chambers Co

Address Riverdale, Md

19. May 18 19 45 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 19 45, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Fractured 3rd cervical vertebra	1 hr.
Due to Injury	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-17-45

Where did injury occur? Beltsville (City or town) P. G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) In a field

Means of injury Airplane Crash Injured at work? Yes

Deputy medical Examiner

23. SIGNATURE ..... M. D. or other

Address ..... Date signed 5-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-C)

CERTIFICATE OF DEATH

05257

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Villa Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Prince Georges

City or town Villa Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5510 Randolph St.
(If rural, give LOCATION)

2.(a) If veteran, name war No.

3. (a) FULL NAME Arthur Leigh Neeley

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jeanette M. Neeley

7. Birth date of deceased (mo., day, yr.) January 28 - 1908 6.(c) If alive, give age 37 years

8. AGE: Years	Months	Days	If less than one day
37	3	21	..... hrs. ..... min.

8. Birthplace Salt Lake City, Utah
(Town, county, and state)

10. Usual occupation Supervisor

11. Industry or business U. S. Post Office Dept.

FATHER 12. Name Arthur O. Neeley

13. Birthplace Colorado

MOTHER 14. Maiden name Ethel L. Hawley

15. Birthplace Utah

16. Informant Mrs. Ethel L. Neeley

Address 5510 Randolph St., Villa Heights Md.

17. Removal Date thereof May 19 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington, D. C.

Location

18. Funeral director L. H. Hines Co.

Address 2901 - 14th St. N.W. Wash., D. C.

19. 5/19 19 45 Amanda Dancy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 19 45 at 5 15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 19 19 45 to May 19 19 45

and that I last saw h... alive on May 19 19 45

	DURATION
Immediate cause of death Acute dilatation right and L Heart	
Due to Rheumatic Heart disease aortic regurgit + mitral	
Due to stenosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George J. Hagerty M. D. or other

Address 3711 - 38th St. Cir Date signed 5-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05258

Reg. Dist. No. 2 42

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fairmont Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

5906 - Kolb

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Fairmont Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5906 - Kolb

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edwina Cleo Payne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 20, 1945

8. AGE: Years | Months: 1 | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D.C.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Edwin Payne

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Augustus Johnson

15. Birthplace: Washington D.C.

18. Informant: Mrs. Augustus Payne

Address: 5906 - Kolb Street

17. Burial — Date thereof: May 21 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Bonney Rd. N.E.

18. Funeral director: J. D. Johnson

Address: Annapolis, Md.

19. May 20 1945 Irene A. Bonner

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Asphyxia	
Due to: Smothering by bed clothing	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 5-17-45

Where did injury occur? Fairmont Heights (City or town) Prince Georges (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Smothered in bed clothes Injured at work?

Dept. Medical Examiner

23. SIGNATURE: [signature] M. D. or other

Address: Forestville, Md. Date signed: 5-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

T5259

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Prince Georges

City or town: Beltsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: In a field

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Missouri County:

City or town: Ramsey Colo.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6805 Elmwood Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Donald Bernard Phillips

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1923

8. AGE:

Years	Months	Days	If less than one day
22	1	17	hrs. min.

9. Birthplace: Boonville, Mo. (Town, county, and state)

10. Usual occupation: A. R. T. 3 Fuse Elec.

11. Industry or business: U. S. Navy

FATHER

12. Name: Samuel Augustus Phillips

13. Birthplace: Ohio

MOTHER

14. Maiden name: Clara Marie Smith

15. Birthplace: Mo.

16. Informant: Papers of Body

Address

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 5-18-45

Cemetery or crematory: 400 Chapin St. N.W.

Location: Wash. D.C.

18. Funeral director: D.W.S. Chambers Co.

Address: Riverdale, Md.

19. (Date rec'd by registrar) May 18 1945 John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral Compression	
Due to: Injury Cranial Cavity	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 5-17-45

Where did injury occur? Beltsville (City or town) Pg. (County) Md. (State)

Injured at home, farm, industry, public place (where?) In a field

Means of injury: Explosion Crash Injured at work? No

23. SIGNATURE: Dep. Path. Med. Officer M. D. or other

Address: Forrestal Bldg. Date signed: 5-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05260

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 4 mo. 2 days

Hospital, institution, or street address where death occurred: Glen Dale Sanatorium

How long in hospital or institution? 2 yrs. 4 mo. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 214 - 2nd St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: POMPEI FREDERICK JOHN

3.(b) Social Security Number: 579-24-3863

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Pompei

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12, 1914

8. AGE:

Years	Months	Days	If less than one day
30	11	17	hrs. min.

9. Birthplace: Philadelphia, Penna. (Town, county, and state)

10. Usual occupation: Baker

11. Industry or business:

FATHER — 12. Name: Lorin Pompei

FATHER — 13. Birthplace: Italy

MOTHER — 14. Maiden name: Elizabeth Iacone

MOTHER — 15. Birthplace: Italy

18. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 29, 1945 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: Wm. J. Lee & Sons.

Address: 300 4½ St. N.E.

19. May 29, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 29, 1945, at 12:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 1, 1943 to MAY 29, 1945 and that I last saw h... alive on MAY 29, 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	8 yrs 5 Mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 5/29/45

VS A15 (M) (1) (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05261

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Colmedy Hills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:
7310 - 7 Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Colmedy Hills
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7310 - 7 Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Mottet Poole

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Poole

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Nov 16, 1890

8. AGE:

Years	Months	Days	If less than one day
54	5	22	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Seymore Poole

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Ella J. Orme

MOTHER 15. Birthplace: Hyattstown Maryland.

16. Informant: Bertha Poole

Address: Colmedy Hills, Md

17. (Burial, cremation, or removal. Which?) Date thereof 5-11-1945 (month) (day) (year)

Cemetery or crematory: Washington National

Location: Cemetery Suitland Md.

18. Funeral director: W. H. Chambers Co.

Address: 517 11th St. S.E. Washington

19. 5/10 1945 (Date rec'd by registrar) Carrie Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1945, at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Acute Coronary thrombosis	
Heart failure	
Due to Cardiovascular	
renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Forestville Md. Date signed: 5-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05202

Reg. Dist. No. 232

1. PLACE OF DEATH:

County: Prince Georges

City or town: Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

Marlboro Theater

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Van Waggoners

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary C. Richards

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William George Richards

6.(c) If wife, give age: years

7. Birth date of deceased (mo., day, yr.): July 11, 1897

8. AGE:

Years	Months	Days	If less than one day
47	10	1	hrs. min.

9. Birthplace: Waldorf, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: William L. Rice

13. Birthplace: Maryland

MOTHER 14. Maiden name: Abbie Brightwell

15. Birthplace: Maryland

18. Informant: William G. Richards

Address: Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15-45 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: Upper Marlboro, Md.

18. Funeral director: Ritchie Brothers

Address: Upper Marlboro, Md.

19. May 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James J. Boyd M. D. or other

Address: Forestville Md Date signed: 5-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05263

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, Institution, or street address where death occurred:

1 - Lake Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 - Lake Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Ross

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Helen Ross

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1892

8. AGE: Years 52 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Rudd Ross

13. Birthplace Maryland

MOTHER 14. Maiden name

15. Birthplace Maryland

16. Informant Helen Ross

Address Takoma Park, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 1 1945 (month) (day) (year)

Cemetery or crematory Paynes Cemetery

Location Washington D.C.

18. Funeral director M. Earnest James

Address 1432 U. St N.W. Washington D.C.

19. June 1 1945 (Date rec'd by registrar) Mrs E. Lyons Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Congestive heart failure	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

Deputy needed Coroner

23. SIGNATURE James H Tough M. D. or other

Address Forestville Md Date signed 5-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

15264

Reg. Diat. No. 230

1. PLACE OF DEATH:

County Prince Georges

City or town Beltsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

Vansville Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland, County Prince Georges

City or town Beltsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Vansville Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Antone Ruperto

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Tomie Ruperto

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	14	hrs. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

FATHER 12. Name Unknown

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Wilbur B Kelly

Address Beltsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-23-45 (month) (day) (year)

Cemetery or crematory St. Johns Cemetery

Location Bladensburg, Md

18. Funeral director Lee Chambers

Address Riverdale Md

19. May 22nd 1945 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Uremia	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner James D Conn M.D. or other

Address Forestville Md Date signed 5-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

05265

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:
County Prince Georges
City or town Forestville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Temporary.
Hospital, Institution, or street address where death occurred: 8200 Marlboro Pike
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Upper Marlboro (If outside city or town limits, write RURAL and give nearest town)
Street No. Hills Landing Road (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha Beatrice Cecilia Sellman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22, 1941.

8. AGE: Years 4 | Months 3 | Days 8 | If less than one day hrs. min.

9. Birthplace Upper Marlboro, Md (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Joseph Edward Sellman
13. Birthplace Maryland
MOTHER 14. Maiden name Florence Veronica Bruce
15. Birthplace Maryland
16. Informant Elsie Sellman
Address Upper Marlboro, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2 - 45. (month) (day) (year)
Cemetery or crematory Mt. Carmel
Location Upper Marlboro, Md.
18. Funeral director Ritchie Brothers
Address Upper Marlboro Md.
19. June 2nd 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945 at 9:35 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Shock	
Due to Fracture of both femurs - mid portion Compounded fracture of both	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 5-30-45
Where did injury occur? Upper Marlboro P.G. (City or town) Md (County) (State)
Injured at home, farm, industry, public place (where)? Hills Landing Road
Means of injury Pedestrian struck by Injured at work? No
Deputy medical examiner
23. SIGNATURE James J. Boyd M. D. or other
Address Forestville Md Date signed 5-30-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-C)

05266

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County: Prince Georges
City or town: Westwood Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: Annapolis Clinic
How long in hospital or institution? 4 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr Georges
City or town: Westwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rose Marie Simms

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Single

6.(b) Name of husband or wife: Husband
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 9 1940

8. AGE: Years 4 | Months 7 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Westwood Md
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: Howard Simms
13. Birthplace: West Wood Md

MOTHER
14. Maiden name: Florence Sewell
15. Birthplace: Westwood Md

16. Informant: Howard Simms
Address: Westwood, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof 5-15-45 (month) (day) (year)
Cemetery or crematory: St John
Location: Upper Marlboro Md

18. Funeral director: Hewitt & Byrne
Address: Waldorf Md

19. 5-15 1945 (Date rec'd by registrar) M. L. Rogers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13th 1945 at 7½ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7 1944 to May 13 1945 and that I last saw h[illegible] alive on Apr 15 1945

Immediate cause of death	DURATION
Consequential Enlargement of Heart	4 Yrs 5 Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: John E. Rovers M.D. M. D. or other
Address: Brandywine Md Date signed: 5/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05267

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mos., 6 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 11 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 443 Delaware Ave. S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: GEORGE W. SMITH

3.(b) Social Security Number: 577-16-9028

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Bertha H. Smith

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): September 7, 1910

8. AGE: Years	Months	Days	If less than one day
34	8	5	..... hrs. ..... min.

9. Birthplace: Johnston, South Carolina (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER — 12. Name: John Alfred Smith

13. Birthplace: Edgefield, South Carolina

MOTHER — 14. Maiden name: Emma Weaver

15. Birthplace: Edgefield, South Carolina

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 13, 1945 (month) (day) (year)

Cemetery or crematory:

Location: to Wash. D.C.

18. Funeral director: Frances Crouch

Address: 1226 Jenn. Ave. N.W.

19. May 12, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 Tue 1945, at 7 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 Tue 1944, to May 12 Tue 1945

and that I last saw h.im alive on May 12 Tue 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 yr. 5 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 5/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

(5268

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince Georges Co
City or town: Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: M.D. County: Prince Georges
City or town: Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 722-60th Pl. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Helen L. Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Smith
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Dec. 25 1880

8. AGE: Years	Months	Days	If less than one day
64	4	24	hrs. min.

9. Birthplace: Prince George, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. FATHER — Name: Unknown
13. Birthplace: Md.
14. MOTHER — Maiden name: Unknown
15. Birthplace: Md.
16. Informant: Mabel Butler
Address: 722-60th Pl, N.E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29-1945 (month) (day) (year)
Cemetery or crematory: Lincoln Memorial
Location: Suitland Md
18. Funeral director: P.B. Johnson
Address: Cabin John Md
19. May 28 1945 Irene A. Conner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24th 1945, at 7P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to May 24 1945 and that I last saw h[illegible] alive on May 24th 1945
Immediate cause of death: Pulmonary Congestion — DURATION
Due to: Endocarditis — acute
Due to: Diabetes
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: —
Date of op.: —
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: no — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J. H. Bruce, M.D.
M. D. or other
Address: 5005 Sheriff Rd. N.E. Date signed: 5-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05269

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4205-28th St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mollie P. Soper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Henry E. Soper
6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 21st 1868

8. AGE: Years	Months	Days	If less than one day
76	11	20	hrs. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Collinson White
13. Birthplace Md.

MOTHER
14. Maiden name Grace Botelee
15. Birthplace Md.

16. Informant Lingan D. Soper
Address 4205-28th St. Mt. Rainier Md.

17. Burial Date thereof May 23rd 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Moncacy Cemetary
Location Bealsville Maryland
18. Funeral director Wm. J. Malley
Address 3200-R.I. Ave. Mt. Rainier Md.

19. May 22, 1945 James Levey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1945, at 11:50 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on May 20, 1945 ~~to~~ 19..... and that I last saw h~~er~~ alive on May 20, 1945

Immediate cause of death	DURATION
Acute Left Ventricular Failure	2 hrs. 50 min.
Due to Cardiovascular Renal Disease	Several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. ~~or other~~
Address Mt. Rainier Md Date signed 5/21/45

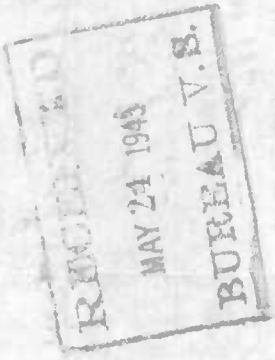
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

~~Coroner~~

Coroner, Dr. James Boyd, personally notified by me 5/20/45 and will approve execution of Certificate by me.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05270

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Greenbelt Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dorothy alice stone

3.(b) Social Security Number:

4. Sex: Female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Raymond stone
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): Aug 10, 1915

8. AGE: Years: 29 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

MOTHER FATHER
12. Name: Raymond Thompson
13. Birthplace: Ky
MOTHER
14. Maiden name: Nella Lariat
15. Birthplace: Ga

16. Informant: Raymond stone
Address: Berwyn Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md

19. Funeral director: F Gaeta sons
Address: Hyattsville Md

19. May 8th 1945 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7. 1945, at 12.45 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 29 1945, to May 7 1945
and that I last saw h alive on May 7, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	7 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Allen Griffith M. D. or other
Address: Berwyn Md Date signed: May 9, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

015271

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, Institution, or street address where death occurred:
6223 - Lee Pl.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6223 - Lee Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Otho Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Mary Boone
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 15 1883

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	2	10		

9. Birthplace: Prince Georges Co. Md.
(Town, county, and state)
10. Usual occupation: Custodian
11. Industry or business: D.C. Public School

FATHER
12. Name: George Thomas
13. Birthplace: Pr. Geo. Co. Md.

MOTHER
14. Maiden name: Nellie Thomas
15. Birthplace: Pr. Geo. Co. Md.

16. Informant: (Mrs.) Bella Brown
Address: 312-10 St. N.W. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19 1945 (month) (day) (year)
Cemetery or crematory: Brandywine
Location: Prince Georges Co. Md.

18. Funeral director: J. B. Johnson
Address: Annapolis, Md.

19. May 18 1945 (Date rec'd by registrar) Irene A. Bonnie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1945 at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1944 to May 15 1945 and that I last saw him alive on May 15 1945

Immediate cause of death	DURATION
(a) Hypertension	?
Due to (b) Cerebral Haemorrhage	-
Due to (c)	?
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. C. Bellon M.D.
M. D. or other
Address: 6223 Lee Pl. N.E. D.C. Date signed: May 15, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05272

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pro Geo Co.
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 days
Hospital, institution, or street address where death occurred: Pro Geo hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Colmar Manor Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3300 - 40th Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Virginia Thompson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Charles Thompson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 13, 1909

8. AGE: Years	Months	Days	If less than one day
35	6	6	..... hrs. ..... min.

9. Birthplace: Va (Town, county, and state)
10. Usual occupation: Telephone Co
11. Industry or business:

FATHER
12. Name: Frank Wammers
13. Birthplace: Va

MOTHER
14. Maiden name: Alice Carr
15. Birthplace: Va

16. Informant: Charles Thompson
Address: Colmar Manor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 1945 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: Colmar Manor Md

18. Funeral director: F Gasch Sons
Address: Hyattsville Md

19. 5/8 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1945 at 7.30 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to May 6 1945
and that I last saw h... alive on May 5 1945

Immediate cause of death: Carcinoma of liver — DURATION: Months
Due to:
Due to:
Other conditions: Post operative ruptured appendix
(Include pregnancy within 3 months of death)

Major findings of operations: Pelvic abscess, ruptured appendix, liver abscess. Date of op. March 22, 1945
Autopsy results: Carcinoma of liver.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: U. Z. Heart md
M. D. or other
Address: 1033 - Monroe NE Wash DC. Date signed May 6, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

County 15273 postal card

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George

City or town Seabrook (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Seabrook (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME GEORGE ANDERSON TINSLEY

3.(b) Social Security Number 719-04-6634

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary D. Tinsley

6.(c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1917

8. AGE: Years	Months	Days	If less than one day
27			hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Interior Decorator

11. Industry or business Own business

FATHER 12. Name Oscar Robert Tinsley

13. Birthplace Virginia

MOTHER 14. Maiden name Mannie Eva Meeks

15. Birthplace Virginia

16. Informant Mrs. Mary D. Tinsley

Address Seabrook, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4, 1945 (month) (day) (year)

Cemetery or crematory Holy Trinity Cemetery

Location Collington, Md.

18. Funeral director F. Gasch's Sons.

Address Hyattsville, Md.

19. May 3 1945 (Date rec'd by registrar) Mrs Jack Bennett D.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/45 19 ..., at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February, 1945, to 5-1 1945

and that I last saw him alive on 4/30/45 19...

Immediate cause of death	Resp. Failure	DURATION
Due to	Tuberculous pneumonia	
Due to	Pulmonary Tuberculosis	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Evans Jr. M.D. M. D. or other

Address 30B. Ridge Rd Greenbelt Md Date signed 5/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Clum

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

T 05274

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co:-
City or town: Hyatterille Md:-
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md:- County: Pro. Geo Co:-
City or town: Hyatterille Md:-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 45-23 Buchanan st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah E. Tucker

3.(b) Social Security Number: — —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Geo Tucker
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 20, 1859.

8. AGE: Years	Months	Days	If less than one day
86	-	-	hrs. min.

9. Birthplace: Va (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: England

MOTHER
14. Maiden name: ? Johnson
15. Birthplace: Unknown

16. Informant: Calvert O. Ward
Address: Hyatterille Md:-

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1945 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Rockville Md:-

18. Funeral director: F. Gascke sons
Address: Hyatterille Md.

19. May 14 (Date rec'd by registrar) 1945 James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1945, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-15-43 19— to 5-12 19 45
and that I last saw h.. alive on 5-12-45 19—

Immediate cause of death: Myocardial failure — DURATION: 3 days
Due to: Senility
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John P. Clum M. D.
M. D. or other
Address: Hyatterille Md Date signed 12-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Counted 15275

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince George
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred: 5902 Central Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5902 Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Agatina Vendemia
3.(b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Frank Vendemia
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.): June 10, 1882
8. AGE: Years 62 Months Days If less than one day ... hrs. ... min.
9. Birthplace: Missoria, Sicily, Italy
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Rafael Bucca
13. Birthplace: Missoria, Sicily
MOTHER 14. Maiden name: Francesca Cossamano
15. Birthplace: Missoria, Sicily
16. Informant: Thomas Vendemia
Address: 5902 Central Ave, Capitol Hts Md
17. Removal (Burial, cremation, or removal, Which?) Date thereof 5-5-45 (month) (day) (year)
Cemetery or crematory: St Marys
Location: Washington DC
18. Funeral director: W. W. Chambers Co
Address: 517 11th St S.E.
19. May 6 1945 (Date rec'd by registrar) Carrie Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1945, at 2:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1945, to May 5 1945
and that I last saw her alive on May 5 1945

		DURATION
Immediate cause of death	Arteriosclerotic heart disease c̄ generalized arteriosclerosis c̄	5 years
Due to	congestive heart failure	6 days
Due to	Diabetes mellitus	12 years
Other conditions	Amputated left leg	3 years

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: William Brennan M.D.
Address: Capitol Heights, Md. Date signed 5/5/45

(I) (T)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

05276

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town) Maryland

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Berwyn Heights Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 5216 Seminole Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Warner Mr. Abraham Isaac

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Lenore O'Malley Warner

6.(c) If alive, give age: 6 3 years

7. Birth date of deceased (mo., day, yr.): November 24 1879

8. AGE: Years: 65 Months: Days: If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Builder (Retired)

11. Industry or business:

MOTHER 12. Name: Rufus Newton Warner

FATHER 13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Annie Hunsicker

MOTHER 15. Birthplace: Pennsylvania

16. Informant: wife Mrs. Lenore O. Warner

Address: 5216 Seminole Ave Berwyn Hgts

17. transportation (Burial, cremation, or removal. Which?) Date thereof: May 11 1945 (month) (day) (year)

Cemetery or crematory: Collegeville, Pa.

Location:

18. Funeral director: F. Gaeth Ford

Address: Hyattsville, Md

19. May 9, 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 1945, at 1 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1945, to May 7 1945

and that I last saw him alive on May 7 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 Days
Due to: Hypertension	
Due to: General Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Cerebral Hemorrhage (Left)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L.W. Malin M.D. M. D. or other

Address: Riverdale, Md Date signed: May 7 1945.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-21)

CERTIFICATE OF DEATH

75277

Reg. Dist. No. 245

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town HYATTSVILLE (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 MONTHS
Hospital, institution, or street address where death occurred:
5801 Queen Chapel Rd.
How long in hospital or institution? 6 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town BETHESDA (If outside city or town limits, write RURAL and give nearest town)
Street No. 6906 BRADLEY BLVD. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME KATHARINE WASSERBACH **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	WIDOWED

6.(b) Name of husband or wife THEODORE WASSERBACH 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUG. 28, 1852

8. AGE: Years 92 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace ALBANY N. Y. (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER 12. Name ARTHUR LOUGHREN
13. Birthplace IRELAND

MOTHER 14. Maiden name ELLEN LYNCH
15. Birthplace IRELAND

16. Informant SACRED HEART HOME
Address HYATTSVILLE, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 5-19-45 (month) (day) (year)
Cemetery or crematory MT. OLIVET
Location WASH. D. C.

18. Funeral director Joseph Gawler's Sons
Address 1756 Pa. Ave. N.W.

19. May 18 1945 James Seivy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945, to May 18 1945
and that I last saw h~~im~~er alive on May 17 1945

Immediate cause of death ..... DURATION
Congestive Heart Failure — 30 days
(Arteriosclerotic Heart disease)
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Thomas A Collins M.D. M. D. or other
Address 322 - H ST. N.E. Date signed May 18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4750)

CERTIFICATE OF DEATH

T 05471

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George

City or town Brentwood

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

3910 Rhode Island Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 35 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Brentwood Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3910 - Rhode Island Ave N. E.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Theresa Wedemeier

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Henry Wedemeier

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) December 25 1854

8. AGE: Years	Months	Days	If less than one day
90			____ hrs. ____ min.

9. Birthplace New York (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Phillip Farrington

13. Birthplace Maine

MOTHER

14. Maiden name Mary O'Leahanly

15. Birthplace Ireland

16. Informant Gertrude Wedemeier

Address 3910 - Rhode Island Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 1945 (month) (day) (year)

Cemetery or crematory Cave Hill Cemetery

Location Louisville Kentuckey

18. Funeral director Frank Geiers Sons Co

Address 3605 - 14 St N.W. Wash. D.C.

19. May 4 1945 (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 2:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1941, to May 3 1945, and that I last saw her alive on May 3 1945

Immediate cause of death	DURATION
Cancer of left lung	7 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles C. Hageage M. D.

M. D. or other

Address Mt. Rainier, Md. Date signed May 4, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-F)

05278

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 11 mos., 3 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 11 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1034 - 33rd St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: FRANK WHITE

3.(b) Social Security Number: - (lost)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Sara White
6.(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): March 10, 1911

8. AGE: Years	Months	Days	If less than one day
34	1	24	...hrs. ...min.

9. Birthplace: Susanah Co., Virginia (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business

FATHER
12. Name: James White
13. Birthplace: Virginia

MOTHER
14. Maiden name: Susie Bradly
15. Birthplace: Virginia

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 5, 1945 (month) (day) (year)
Cemetery or crematory: Ft. Washington Cem.
Location: D. C.

18. Funeral director: Taft H. Williams
Address: 2201 - 9th Ave N.W.

19. May 4, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 4, 1945 at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 1, 1943 to MAY 4, 1945 and that I last saw h... alive on MAY 4, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs 4 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 5/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

05279

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hillcrest Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mo
Hospital, Institution, or street address where death occurred: 5215- N Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hillcrest Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5215- N Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jake Ella Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: William Samuel Williams
6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) June 26, 1900

8. AGE: Years 42 | Months 10 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Cleaner
11. Industry or business: Safeway Stores

FATHER
12. Name: Braxton W. Williams
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lelia Vaught
15. Birthplace: Virginia

16. Informant: Roy A. Kellam
Address: 2300 49th St, Bladensburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1945 (month) (day) (year)
Cemetery or crematory: Christiansburg, Va.
Location:

16. Funeral director: Martin W. Hysong Co.
Address: 1300-N 22 N.W. Wash. 5, D.C.

19. 5-17 19 45 (Date rec'd by registrar) Thos. O. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1945, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Carcinoma of Pancreas	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy medical Examiner
23. SIGNATURE: James D. Bond M. D. or other
Address: Forestville, Md. Date signed 5-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15